MDR Tracking Number: M5-04-3865-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 07-12-04.

The IRO reviewed office visits, therapeutic activities, neuromuscular reeducation, range of motion measurements and manual muscle testing rendered from 01-12-04 through 02-24-04 that were denied based "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 09-14-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99080-73 date of service 02-20-04 denied with denial code "V". This is a TWCC required report and will be reviewed as a fee issue. The requestor did not submit relevant information to support delivery of service. No reimbursement is recommended for CPT code 99080-73 for date of service 02-20-04.

This Findings and Decision is hereby issued this 4th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

September 10, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-3865-01
TWCC #:
Injured Employee:

Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ------. The patient reported that while at work he injured his back while attempting to load boxes onto a van. A MRI of the lumbar spine performed 12/9/03 indicated a mild lateralizing disc bulge at L2-3, a mild diffuse disc bulge and left posterolateral disc protrusion at the L3-4, a mild diffuse disc bulge and small left posterolateral annular fissure without visible neural impingement at L4-5, and a mild disc bulge without visible neural impingement at L5-S1. Treatment for this patient's condition has included passive and active therapy, and therapeutic exercises.

Requested Services

Office visits 99211, 99212 and 99213, therapeutic activities, neuromuscular reeducation, range of motion measurements, and manual muscle testing from 1/12/04-2/24/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. SOAP notes 11/24/03 – 2/24/04
2. MRI report 12/9/03

Documents Submitted by Respondent:

1. MRI report 4/4/03
2. X-ray report 3/22/03

3. Initial Evaluation 4/1/03
4. Operative note 4/23/03
5. Office notes/treatment logs 5/2/03 – 8/22/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a 53 year-old male who sustained a work related injury on ------. The ------ chiropractor reviewer also noted that the diagnoses for this patient have included unspecified disc and back disorders, lumbar facet syndrome and sprain of the hip and thigh. The ------ chiropractor reviewer indicated that although the patient was injured on ------, he did not seek treatment until 7 months after the injury. The ------ chiropractor reviewer noted that the patient received three months of chiropractic care, along with numerous exercises and neuromuscular reeducation. The ------ chiropractor reviewer indicated that the patient continued to have complaints of low back pain and left thigh and hip pain and that the findings remained the same throughout his care. The ------ chiropractor reviewer explained that these findings reveal a patient who has not received significant lasting benefit from his chiropractic care. The ------ chiropractor reviewer also explained that while a short trial of chiropractic care is reasonable, ongoing care without evidence of objective changes is not. The ------ chiropractor reviewer further explained that for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time frame. The ------ chiropractor reviewer indicated that the type, frequency and duration of services must be reasonable and consistent with standards of practice in the chiropractic community. The ------ chiropractor reviewer explained that additional treatment would be necessary if objective benefit can be demonstrated. The ------ chiropractor reviewer indicated that there is little evidence to support that this patient has benefited from the treatment rendered. The ------ chiropractor reviewer explained that there is no evidence that additional care has changed the treatment outcome for this patient. The ------ chiropractor reviewer further explained that treatment for this patient has exceeded treatment guidelines such as the American College of Occupational and Environmental Medicine Guidelines, as well as the Mercy Guidelines. Therefore, the ------ chiropractor consultant concluded that the office visits 99211, 99212 and 99213, therapeutic activities, neuromuscular reeducation, range of motion measurements, and manual muscle testing from 1/12/04-2/24/04 were not medically necessary to treat this patient's condition.

Sincerely,